Box 1 JCAHO

The JCAHO, founded over 50 years ago, has a declared mission to improve continuously the safety and quality of care provided to the public. A major role is to identify the cause of harmful errors and facilitate their reduction through analysis, reporting, implementation, and monitoring of any applied policies. An effective reporting system is an essential prerequisite for serious event analysis and needs to be within a framework that allows the information to be legally protected from disclosure so that data can be seen as *Sentinel Event Alerts*. Data from the analysis of reported serious events are used as the foundation for the formulation and implementation of safety and quality guidelines.

in identical circumstances. Patient involvement seems simple but is, in fact, a major shift in emphasis. Despite evidence from the airline industry where safety is also paramount, the junior staff have clear instructions to challenge their seniors in situations of potential error whereas in surgery the likelihood of the junior surgeons and staff challenging their senior colleagues is much less likely.[11] Indeed, in the case of the patient whose wrong kidney was removed, it is reported that a medical student present in the operating theatre did suggest wrong side surgery. Any guidelines issued must therefore provide backing for issues that may arise from this challenge.

The JCAHO has shown the way with the reporting and analysis of these incidents. We must ask whether there is any reason why the UK should not adopt the protocol that has emerged from their experience.

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''No blame'' culture

Creating a ''no blame'' culture: have we got the balance right?

M Walton

There is a need to clarify where and how professional responsibility fits into the ''no blame'' culture

How the media reports patient harm associated with adverse events continues to cause public concern and disturb health professionals. The need for health professionals to communicate more effectively with the public about medical errors has been identified,[1 2] but to date there is little evidence of this happening. Tensions surrounding professional responsibility and accountability (as opposed to institutional accountability) and the quality and safety ''no blame'' approach within the health system prevent health professionals communicating clearly with the public. How can we give a clear message to the public when we do not have a clear understanding of these issues ourselves?

The current focus on improving care by redesigning systems, tasks and workforce[3] necessarily emphasises the multiple factors underpinning errors, relies on reporting systems for capturing errors, and advocates a ''blame free'' environment so that staff will report their mistakes or near misses. This approach examines system factors as causes of errors rather than individuals. Evidence from other industries and disciplines supports this approach.

The safety agenda requires us to switch from an individual focus to a system focus but, in making this switch, professional accountability has been cast as the ''black sheep'' of safety improvement. Undeveloped systems of professional accountability, inadequate support from professional bodies for professional regulation, inadequate understanding of public interest, and inadequate rules for reporting serious misconduct have let this happen. This is no criticism of safety advocates whose job is to reduce patient injury: too many messages can be detrimental to success. But have we got the balance right? System theorists and industries upon which health relies for systems redesign and remedies pay a lot of attention to the role violations play in the system. Reason[4] argues that, in addition to a systems approach to error management, we need effective regulators with the appropriate legislation, resources and tools. Regulators, being separate from organisations, are best placed to identify unsatisfactory work practices or conditions that workers tolerate or work around.

The perceived contest between whether individuals or bad systems cause patient injuries has confused many health professionals and managers. It is not a case of accepting one over the other. The focus on the system as the problem does not mean that

m as the problem does not mean that individuals do not have to maintain competence and practice ethically or be called to account when they act unprofessionally. Accentuating the system and downplaying professional responsibility may be politically expedient to some groups, particularly those professional groups opposed to external scrutiny. But sacrificing professional accountability increases the risks to patients. The failure to urge professional responsibility concurrently with calls for a ''blame free'' approach to error reporting sends the public the message that the health system favours one above the other.

UNDERSTANDING VIOLATIONS

Patients making complaints about their health care are entitled to have their individual care examined to see if there has been a departure from the required standard. System issues may be the main cause. But health providers may also have cut corners and broken rules. Medical standards may have been breached and substandard care provided. Rules are broken so often in hospitals—for example, non-compliance with a protocol such as failure to wash hands—that we have become immune to them. It is easier to blame such violations solely on the system than to require individuals to meet their professional responsibilities. Reason defines a violation as a deviation from safe operating procedures, standards, or rules.[4] He categories violations as routine, optimising, and necessary. The first two relate to personal characteristics while necessary violations are linked to organisational failures. Cutting corners are routine violations that thrive in work environments that rarely sanction violations or reward compliance[4]—for example, not following protocols, inadequate handovers, inadequate infection control, and not attending on-call requests. Optimising violations involve individuals motivated by personal goals such as greed or thrills from risk taking—for example, letting inexperienced junior staff operate without supervision when a consultant is busy with private patients, experimenting with unproven procedures, and doing inappropriate procedures. Necessary violations comprise work environments and circumstances which force workers to break rules to get the job done. Deliberate violations—those where there is an intention to act as distinct from a violation caused through ignorance—are recognised and managed. Intentional violations do not necessarily intend a bad outcome.[4] Poor understanding of professional obligations and a weak infrastructure for managing unprofessional behaviour in hospitals provide fertile ground for aberrant behaviour to flourish.

LEARNING FROM THE PAST

The main avenue of redress for patients suffering adverse events during the 1980s and 1990s was to make a complaint. Health professions and organisations were deaf to stories of inadequate or substandard treatments and focused on the messengers (regulatory authorities, consumer groups, complaint agencies, or lawyers) as the problem. Professional accountability was the focus of these investigations, with no attention to the role played by the system. We should learn from that experience. Just as it was wrong in the past to focus only on individuals, it is equally wrong today to think that all adverse outcomes are caused by systems problems with no attention to professional duties and responsibilities.

A WAY FORWARD

In my experience as both a regulator and safety exponent,* systems issues usually accompany breaches of professional responsibility (weak regulations, reporting requirements, or inadequate training). It depends how you look and where. A root cause analysis[5] would nearly always identify systems problems and rarely individuals. Systems failures may also mitigate the level of responsibility for the individuals. Where and how professional responsibility fits into the ''no blame'' culture is unclear. How can we make it clearer?

Public trust requires both a redesigned health system delivering safe and quality health care and a strong professional ethic and accompanying accountability system. As a first step, three things should happen:

- professionalism in the workplace needs to become part of the safety agenda;
- methods for managing and responding to intentional violations by individuals in the workplace need to be debated and designed: building in sanctions for routine violations and rewards for workplace compliance is a first step;
- teaching clinicians about the inevitability of mistakes is already happening but we also need to teach them how to respond to mistakes.

Disciplinary outcomes for doctors are largely determined by peer review and focus on the actions taken after the mistake rather than the mistake itself.[6] Demystifying accountability mechanisms and educating professionals about their ethical obligations will help them identity systems problems and the appropriate remedies and professional issues and their appropriate response.

*The author was the NSW Health Care Complaints Commissioner (1995–2000) and is now the Chair of the Personal and Professional Development Theme in the Faculty of Medicine University of Sydney undertaking research on quality and safety and teaching students and medical clinicians about ethical practice, quality improvement and safety.

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